House File 2389

H-8039

Amend House File 2389 as follows:

1. By striking everything after the enacting clause and inserting:

<DIVISION I

FAMILY PLANNING AND ABORTION REDUCTION POLICY

Section 1. FAMILY PLANNING AND ABORTION REDUCTION POLICY.

1. a. In 2011, nearly two million eight hundred thousand pregnancies, or forty-five percent of pregnancies, were unintended, meaning that the pregnancy occurred when a woman wanted to become pregnant in the future but not at the time she became pregnant, or the woman became pregnant when she did not want to become pregnant then or at any time in the future.

b. The rate of unintended pregnancies is higher among women with incomes below two hundred percent of the federal poverty level (FPL), women eighteen to twenty-four years of age, cohabiting women, and women of color, and is lowest among higher-income women, white women, college graduates, and married women. With respect to the outcome of an unintended pregnancy, in 2011, women with incomes below one hundred percent of the FPL had an unplanned birth rate nearly seven times that of women at or above two hundred percent of the FPL.

2. a. Between 2008 and 2011, the unintended pregnancy rate in the United States declined by eighteen percent, the lowest level in three decades. During this time, the rates of both abortion and unplanned births fell substantially by thirteen percent and eighteen percent, respectively. Abortion rates have continued to decline and although states enacted new restrictions on abortions between 2012 and 2014, these states only accounted for thirty-eight percent of the total abortion rate decline between 2011 and 2014. Conversely, sixty-two percent of the decline in the abortion rate was attributable to states and jurisdictions that did not pass restrictive abortion laws during this same time period. This suggests that the decline in the abortion rate during both periods was not due to an increase in unplanned births or increased abortion

restrictions.

b. During these periods, however, there was improvement in contraceptive use, including the use of highly effective long-acting reversible contraceptives. Based on this data, researchers have concluded that the decline in abortions was driven by the steep decline in unintended pregnancy, which in turn was most plausibly explained by improved contraceptive use, not because fewer women decided to end an unwanted pregnancy.

3. a. According to the centers for disease control and prevention of the United States department of health and human services (CDC), two million three hundred thousand cases of chlamydia, gonorrhea, and syphilis were reported in the United States in 2017, the highest number ever, and two hundred thousand more than in 2016. Of these cases, the population aged fifteen to twenty-four accounted for more than one-half of all new sexually transmitted infections (STIs) each year, even though that population makes up only one-quarter of the sexually active population. Sexually transmitted infections are disproportionately more common in young and marginalized people.

b. If left undiagnosed and untreated, STIs can have serious health consequences, resulting in infertility, life-threatening ectopic pregnancies, stillbirths in infants, and miscarriages, and an increased risk for human immunodeficiency virus transmission. Additionally, STIs may result in adverse pregnancy outcomes including preterm birth, low-birth weight, and children with physical and mental developmental disabilities.

c. The CDC identifies budgetary cuts in STI prevention efforts, societal stigma, insufficient awareness of the importance of screening among some health care providers, lack of comprehensive sex education, and barriers to health care services as playing roles in the increase in STIs.

4. a. The CDC and the United States office of population

affairs recommend that family planning services include providing contraception to help men and women plan and space births, prevent unintended pregnancies, and reduce the number of abortions; offer pregnancy testing and counseling; help clients who want to conceive; provide basic infertility services; provide preconception health service to improve infant and maternal outcomes, and improve women's and men's health; and provide STI screening and treatment services to prevent tubal infertility and improve the health of women, men, and infants.

b. In 2014, of the sixty-seven million women of reproductive age, ages thirteen to forty-four, thirty-eight million were in need of contraceptive care, and twenty million were in need of publicly funded services and supplies due to being low-income or being younger than twenty years of age.

c. In 2015, public expenditures for family planning client services totaled two billion one hundred million dollars with Medicaid accounting for seventy-five percent, state appropriations accounting for twelve percent, and funding through Title X of the federal Public Health Services Act (Title X) accounting for ten percent. Title X subsidizes services for men and women who do not meet the eligibility requirements for Medicaid, maintains the national network of family planning centers, and sets the standards for provision of family planning services.

d. Although total public funding for family planning in actual dollars increased by more than one billion seven hundred million dollars between 1980 and 2015, after adjusting for inflation, funding levels were essentially the same in 2015 as in 1980.

e. In 2010, every one dollar invested in publicly funded family planning services saved over seven dollars in Medicaid expenditures that would otherwise have been necessary to pay the medical costs of pregnancy, delivery, and early childhood care; and the nationwide public investment in family planning

services resulted in over thirteen billion dollars in net savings, helping women avoid unintended pregnancies and a range of other negative reproductive health outcomes.

f. In 2014, publicly funded family planning services helped women to avoid two million unintended pregnancies, which would potentially have resulted in nearly nine hundred thousand unplanned births and nearly seven hundred thousand abortions.

g. Publicly funded family planning has well-documented health benefits for women, newborns, families, and communities. The ability to delay and space out childbearing is crucial to women's social and economic advancement. A woman's ability to obtain and effectively use contraceptives has a positive impact on their education and workforce participation, as well as on subsequent outcomes related to income, family stability, mental health and happiness, and children's well-being. Evidence suggests that the most disadvantaged women in the United States do not fully share in these benefits which is why unintended pregnancy prevention efforts should be grounded in broader anti-poverty and social justice efforts.

h. Publicly funded family planning services help women to avoid pregnancies they do not want and to plan pregnancies they do. Supporting and expanding women's access to family planning services not only protects women's health, it also reduces abortion rates. The clear implication for policymakers who wish to see fewer abortions occur is to focus on making family planning services and contraceptive care more available and increasing funding to these services.

DIVISION II

MEDICAID —— IOWA FAMILY PLANNING NETWORK

Sec. 2. MEDICAID —— IOWA FAMILY PLANNING NETWORK.

1. The Medicaid 1115 demonstration waiver provided family planning services, at various time periods, from February 2006 through June 2017, to men and women ages twelve to fifty-four with incomes not exceeding three hundred percent of the federal poverty level, through the Iowa family planning network.

Services provided by the Iowa family planning network during this time did all of the following:

a. Resulted in an estimated midpoint number of averted births, including by extension the reduction in unintended or unwanted pregnancies and repeat teen births, of thirty-six thousand one hundred sixty-nine.

b. Resulted in an estimated midpoint reduction in Medicaid costs attributable to costs avoided for each averted birth including costs for deliveries, births, and first years of life of four hundred eighty-five million dollars, not including the continuing costs for children who remain on Medicaid beyond their first birthday. Approximately forty percent of children who had a Medicaid-paid birth will remain on Medicaid for five or more years.

c. Resulted in a total estimated net savings in Medicaid costs of over four hundred seventy-six million dollars.

d. Provided a cost-effective mechanism to allow men and women access to family planning services which resulted in averted births and reduced costs to the state with the ninety percent federal match for such services.

2. Conversely, data reported regarding the state family planning program established July 1, 2017, and funded exclusively with state general fund moneys, indicates that from April through June of 2018, there was a seventy-three percent decline in services compared with April through June 2017, the last three months of the Iowa family planning network, and patient enrollment in the new program fell by more than half.

3. If family planning services were once again provided under the Medicaid program through a Medicaid state plan amendment, with the same benefits, eligibility requirements, and other provisions included in the former Iowa family planning network demonstration waiver, the state would be able to do all of the following:

a. Utilize the additional state funds available to expand efforts to continue to reduce abortions and improve

reproductive and overall health for men and women in the state through broad-based family planning services, age-appropriate sexual health education efforts such as the personal responsibility and education program, programs for pregnant and parenting teens, increased access to family planning services including contraceptives to men and women, Medicaid-enhanced prenatal services for members determined to be at high risk, and the Title X family planning program.

b. Utilize the entire family planning services provider network to expand access to reach those in need of publicly funded services, including those women for whom rates of unintended pregnancies are higher including low-income, younger, and less-formally educated women, and women of color.

c. Continue to provide necessary family planning services that have resulted in declining unintended pregnancies and fewer abortions, and that would result in additional resources being available to enhance the quality of life for children after they are born including through the head start program, prekindergarten programs, child care assistance, properly funded schools, foster and adoptive programs, hawk-i, and other programs that support and enrich the lives of children and families in the state.

Sec. 3. IOWA FAMILY PLANNING NETWORK —— MEDICAID STATE PLAN AMENDMENT. The department of human services shall submit a Medicaid state plan amendment to the centers for Medicare and Medicaid services of the United States department of health and human services for approval to establish the Iowa family planning network with the same benefits, eligibility requirements, and other provisions included in the Medicaid Iowa family planning network waiver as approved by the centers for Medicare and Medicaid services of the United States department of health and human services in effect on June 30, 2017.

Sec. 4. EFFECTIVE DATE. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

DIVISION III

REPEAL OF STATE FAMILY PLANNING SERVICES PROGRAM

Sec. 5. REPEAL. Section 217.41B, Code 2022, is repealed.

Sec. 6. CONTINGENT EFFECTIVE DATE. The following takes effect upon receipt of approval by the department of human services from the centers for Medicare and Medicaid services of the United States department of health and human services of the Medicaid state plan amendment submitted pursuant to division II of this Act to establish the Iowa family planning network:

The section of this division of this Act repealing section 217.41B, Code 2022.

DIVISION IV

SELF-ADMINISTERED HORMONAL CONTRACEPTIVES

Sec. 7. Section 155A.3, Code 2022, is amended by adding the following new subsections:

NEW SUBSECTION. 10A. "*Department*" means the department of public health.

NEW SUBSECTION. 45A. "*Self-administered hormonal contraceptive*" means a self-administered hormonal contraceptive that is approved by the United States food and drug administration to prevent pregnancy. "*Self-administered hormonal contraceptive*" includes an oral hormonal contraceptive, a hormonal vaginal ring, and a hormonal contraceptive patch, but does not include any drug intended to induce an abortion as defined in section 146.1.

NEW SUBSECTION. 45B. "*Standing order*" means a preauthorized medication order with specific instructions from the medical director of the department to dispense a medication under clearly defined circumstances.

Sec. 8. NEW SECTION. **155A.49 Pharmacist dispensing of self-administered hormonal contraceptives —— standing order —— requirements —— limitations of liability.**

1. Notwithstanding any provision of law to the contrary, a pharmacist may dispense, at one time, up to a one-year supply

of a self-administered hormonal contraceptive to a patient, pursuant to a standing order established by the medical director of the department in accordance with this section.

2. A pharmacist who dispenses a self-administered hormonal contraceptive in accordance with this section shall not require any other prescription drug order authorized by a practitioner prior to dispensing the self-administered hormonal contraceptive to a patient.

3. The medical director of the department may establish a standing order authorizing the dispensing of self-administered hormonal contraceptives by a pharmacist who does all of the following:

a. Complies with the standing order established pursuant to this section.

b. Retains a record of each patient to whom a self-administered hormonal contraceptive is dispensed under this section and submits the record to the department.

4. The standing order shall require a pharmacist who dispenses self-administered hormonal contraceptives under this section to do all of the following:

a. Complete a standardized training program and continuing education requirements approved by the board in consultation with the department that are related to prescribing self-administered hormonal contraceptives and include education regarding all contraceptive methods approved by the United States food and drug administration.

b. Obtain a completed self-screening risk assessment, approved by the department in collaboration with the board and the board of medicine, from each patient prior to dispensing the self-administered hormonal contraceptive to the patient.

c. Provide the patient with all of the following:

(1) Written information regarding all of the following:

(a) The importance of completing an appointment with the patient's primary care or women's health care practitioner to obtain preventative care, including but not limited to

recommended tests and screenings.

(b) The effectiveness and availability of long-acting reversible contraceptives as an alternative to self-administered hormonal contraceptives.

(2) A copy of the record of the pharmacist's encounter with the patient that includes all of the following:

(a) The patient's completed self-screening risk assessment.

(b) A description of the contraceptive dispensed, or the basis for not dispensing a contraceptive.

(3) Patient counseling regarding all of the following:

(a) The appropriate administration and storage of the self-administered hormonal contraceptive.

(b) Potential side effects and risks of the self-administered hormonal contraceptive.

(c) The need for backup contraception.

(d) When to seek emergency medical attention.

(e) The risk of contracting a sexually transmitted infection or disease, and ways to reduce such a risk.

5. The standing order established pursuant to this section shall prohibit a pharmacist who dispenses a self-administered hormonal contraceptive under this section from doing any of the following:

a. Requiring a patient to schedule an appointment with the pharmacist for the prescribing or dispensing of a self-administered hormonal contraceptive.

b. Dispensing self-administered hormonal contraceptives to a patient for more than twenty-four months after the date a self-administered hormonal contraceptive is initially dispensed to the patient without the patient's attestation that the patient has consulted with a primary care or women's health care practitioner during the preceding twenty-four months.

c. Dispensing a self-administered hormonal contraceptive to a patient if the results of the self-screening risk assessment completed by a patient pursuant to subsection 4, paragraph *"b"*, indicate it is unsafe for the pharmacist to dispense the

self-administered hormonal contraceptive to the patient, in which case the pharmacist shall refer the patient to a primary care or women's health care practitioner.

6. A pharmacist who dispenses a self-administered hormonal contraceptive and the medical director of the department who establishes a standing order in compliance with this section shall be immune from criminal and civil liability arising from any damages caused by the dispensing, administering, or use of a self-administered hormonal contraceptive or the establishment of the standing order. The medical director of the department shall be considered to be acting within the scope of the medical director's office and employment for purposes of chapter 669 in the establishment of a standing order in compliance with this section.

7. The department, in collaboration with the board and the board of medicine, and in consideration of the guidelines established by the American congress of obstetricians and gynecologists, shall adopt rules pursuant to chapter 17A to administer this chapter.

Sec. 9. Section 514C.19, Code 2022, is amended to read as follows:

514C.19 Prescription contraceptive coverage.

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a group policy, ~~or~~ contract, or plan providing for third-party payment or prepayment of health or medical expenses shall ~~not do either of the following~~ comply as follows:

a. ~~Exclude~~ Such policy, contract, or plan shall not exclude or restrict benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and which are approved by the United States food and drug administration, or generic equivalents approved as substitutable by the United States food and drug administration, if such policy, ~~or~~ contract, or plan provides benefits for other outpatient prescription drugs or devices.

However, such policy, contract, or plan shall specifically provide for payment of a one-year supply of self-administered hormonal contraceptives, as prescribed by a practitioner as defined in section 155A.3, or as prescribed by standing order and dispensed by a pharmacist pursuant to section 155A.47, including self-administered hormonal contraceptives dispensed at one time.

b. ~~Exclude~~ Such policy, contract, or plan shall not exclude or restrict benefits for outpatient contraceptive services which are provided for the purpose of preventing conception if such policy, ~~or~~ contract, or plan provides benefits for other outpatient services provided by a health care professional.

2. A person who provides a group policy, ~~or~~ contract, or plan providing for third-party payment or prepayment of health or medical expenses which is subject to subsection 1 shall not do any of the following:

a. Deny to an individual eligibility, or continued eligibility, to enroll in or to renew coverage under the terms of the policy, ~~or~~ contract, or plan because of the individual's use or potential use of such prescription contraceptive drugs or devices, or use or potential use of outpatient contraceptive services.

b. Provide a monetary payment or rebate to a covered individual to encourage such individual to accept less than the minimum benefits provided for under subsection 1.

c. Penalize or otherwise reduce or limit the reimbursement of a health care professional because such professional prescribes contraceptive drugs or devices, or provides contraceptive services.

d. Provide incentives, monetary or otherwise, to a health care professional to induce such professional to withhold from a covered individual contraceptive drugs or devices, or contraceptive services.

3. This section shall not be construed to prevent a third-party payor from including deductibles, coinsurance, or

copayments under the policy, ~~or~~ contract, or plan as follows:

a. A deductible, coinsurance, or copayment for benefits for prescription contraceptive drugs shall not be greater than such deductible, coinsurance, or copayment for any outpatient prescription drug for which coverage under the policy, ~~or~~ contract, or plan is provided.

b. A deductible, coinsurance, or copayment for benefits for prescription contraceptive devices shall not be greater than such deductible, coinsurance, or copayment for any outpatient prescription device for which coverage under the policy, ~~or~~ contract, or plan is provided.

c. A deductible, coinsurance, or copayment for benefits for outpatient contraceptive services shall not be greater than such deductible, coinsurance, or copayment for any outpatient health care services for which coverage under the policy, ~~or~~ contract, or plan is provided.

4. This section shall not be construed to require a third-party payor under a policy, ~~or~~ contract, or plan to provide benefits for experimental or investigational contraceptive drugs or devices, or experimental or investigational contraceptive services, except to the extent that such policy, ~~or~~ contract, or plan provides coverage for other experimental or investigational outpatient prescription drugs or devices, or experimental or investigational outpatient health care services.

5. This section shall not be construed to limit or otherwise discourage the use of generic equivalent drugs approved by the United States food and drug administration, whenever available and appropriate. This section, when a brand name drug is requested by a covered individual and a suitable generic equivalent is available and appropriate, shall not be construed to prohibit a third-party payor from requiring the covered individual to pay a deductible, coinsurance, or copayment consistent with subsection 3, in addition to the difference of the cost of the brand name drug less the maximum covered amount

for a generic equivalent.

6. A person who provides an individual policy, ~~or~~ contract, or plan providing for third-party payment or prepayment of health or medical expenses shall make available a coverage provision that satisfies the requirements in subsections 1 through 5 in the same manner as such requirements are applicable to a group policy, ~~or~~ contract, or plan under those subsections. The policy, ~~or~~ contract, or plan shall provide that the individual policyholder may reject the coverage provision at the option of the policyholder.

7. *a.* This section applies to the following classes of third-party payment provider contracts, ~~or~~ policies, or plan delivered, issued for delivery, continued, or renewed in this state on or after ~~July 1, 2000~~ January 1, 2023:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) Any other entity engaged in the business of insurance, risk transfer, or risk retention, which is subject to the jurisdiction of the commissioner.

(5) A plan established pursuant to chapter 509A for public employees.

b. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

8. This section shall not be construed to require a third-party payor to provide payment to a practitioner for the

dispensing of a self-administered hormonal contraceptive to replace a self-administered hormonal contraceptive that has been dispensed to a covered person and that has been misplaced, stolen, or destroyed. This section shall not be construed to require a third-party payor to replace covered prescriptions that are misplaced, stolen, or destroyed.

9. For the purposes of this section:

a. "Self-administered hormonal contraceptive" means a self-administered hormonal contraceptive that is approved by the United Sates food and drug administration to prevent pregnancy. *"Self-administered hormonal contraceptive"* includes an oral hormonal contraceptive, a hormonal vaginal ring, and a hormonal contraceptive patch, but does not include any drug intended to induce an abortion as defined in section 146.1.

b. "Standing order" means a preauthorized medication order with specific instructions from the medical director of the department of public health to dispense a medication under clearly defined circumstances.>

2. Title page, line 1, by striking <medication abortions including required> and inserting <a family planning and abortion reduction policy, and including a repeal and effective date provisions.>

3. Title page, by striking lines 2 and 3.

BROWN-POWERS of Black Hawk